TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-2589-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After review the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $316.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for New Hampshire Insurance Co is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on May 10, 2017.

28 Texas Administrative Code §133.307(d)(1) states:

> Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute**. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received from Flahive, Ogden & Latson to date. The Division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the Division will base its decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1 – 2, 2017	96374	$316.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 00137 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
    - W3 – Request for reconsideration
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What is the applicable rule that pertains to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $316.96 for outpatient hospital services with date of service February 2, 2107. The carrier reduced the payment amount as 00137 (97) – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." The service in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

    The relevant portions of 28 Texas Administrative Code 134.403 are:

    > (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise
    >
    > > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
    >
    > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

Review of Medicare CCI edits at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html finds Code 96374 – "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance" has an edit with Code 26320 – "Removal of implant from hand" and not separately payable as billed. Therefore, the carrier's denial is supported. No additional payment is recommended.

2. The allowed reimbursement per the applicable Medicare payment policy for the disputed services is $0.00. The carrier has paid $0.00. No additional payment recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 16, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.